

**ADDRESSING VA OPIOID PRESCRIPTION AND PAIN
MANAGEMENT PRACTICES**

FIELD HEARING

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS**

OF THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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ADDRESSING VA OPIOID PRESCRIPTION AND PAIN MANAGEMENT PRACTICES

Friday, March 4, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:30 a.m., at National Guard Headquarters, 1 Minuteman Way, Concord, New Hampshire, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman and Kuster.

Also Present: Representative Guinta

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Mr. COFFMAN. Good morning. This hearing is to come to order.

I want to welcome everyone to today's hearing on opioid addiction and VA's implementation of alternative treatments for chronic pain. First, as a preliminary matter, I would like to ask unanimous consent that Representative Frank Guinta be allowed to join us on the dais today.

Hearing no objection, so ordered.

I would like to begin by putting today's hearing in context. According to media reports, in 2003 the Los Angeles listed Dr. John Sturman, Jr. in its section on "bad docs." That same year, the Medical Board of California reported administrative actions against Dr. Sturman for failures pertaining to a controlled drug. In 2012, Dr. Sturman's medical privileges were reportedly suspended after a number of patients died due to opiate-related prescriptions while under his care.

In April 2015, Dr. Sturman was hired by VA, and by August 2015, Dr. Sturman was arrested at the VA Medical Center in Danville, Illinois due to the many years of investigative work by Indiana's Medicaid Fraud Control Unit. Dr. Sturman is now facing multiple felony charges for over prescribing narcotics related to pain management. In all, media reports that "Fifteen patients died of overdose or toxicity within a month of receiving treatment from Dr. Sturman between 2009 and 2015."

It is bad enough that VA did not properly review Dr. Sturman's history before hiring him, but what makes this issue even more egregious is that with nearly a decade of public failures related to opiates, Dr. Sturman was hired to be the chief of opiate safety.

Now, looking at opiate safety from a broader perspective, according to an inspector general's report issued in May 2014, more than 50 percent of the veteran population experiences chronic pain. VA's response to chronic pain has mainly been prescribing larger amounts of opioids as evident in VA's own data which showed an increase of 77 percent between 2004 and 2014 in VA outpatient care.

In 2013, VA unveiled the Opioid Safety Initiative, which was supposed to promote alternative methods of pain control such as acupuncture and chiropractic care while reducing the dosages of prescriptions for opioid medications. But I am concerned that VA's promotion of alternative methods of pain control may be limited. According to the National PTSD Center, VA states that, "Most Medicaid Center of Mental Health Programs offer alternative therapies," but it's the qualifier most that has me concerned.

One of the issues I want to get into today is how VA's central office captures data on efficacy of alternative treatments. As we talked about in our hearing on this topic on June 10th, 2015, there have been countless examples of veterans being over medicated or experiencing adverse drug reactions due to improper treatment or nonexistent monitoring.

We know that some VA medical centers are exploring new ways of controlling chronic pain. According to an article published in April 2015, the Bronx VA is focusing on physical rehabilitation, and that effort has resulted in the lowest rate of opiate prescriptions in any hospital in the VA health care system. Likewise, the VA Medical Center in White River Junction is said to have designed programs to relieve pain without strong medications, to include acupuncture, yoga, and aquatic therapy as alternatives. However, what is unclear is whether or not this effort is managed at VA Central Office, and how best practices are implemented or shared across the VA.

The Department cannot simply introduce well-intended programs and then fail to manage them properly. If these alternative treatments truly work, they need to be implemented throughout VA and not merely be relegated to a SharePoint server for others to access if they are interested.

With that, I now yield to Ranking Member Kuster for any opening remarks that she may have.

OPENING STATEMENT OF ANN M. KUSTER, RANKING MEMBER

Ms. KUSTER. Well, thank you, Chairman Coffman, and thank you for being with us here in New Hampshire. I just want to express my appreciation for bringing the House Veterans' Affairs Oversight and Investigations Subcommittee to New Hampshire. It is a great honor for me to have you here, and thank you, Mr. Guinta for joining us.

I want to thank all of our witnesses who are here with us today and express my pride that New Hampshire and, in particular, our White River Junction VA, right on the border with Vermont, but serving New Hampshire patients and Manchester, both have stories to tell that we can share across the VA to make sure that we are treating veterans both for managing their pain and to make sure we bring down the rate of opioid use.

You know, this is a big issue. I do not need to remind anyone in the audience from New Hampshire this now polls as the number one issue in New Hampshire for voters and constituents in terms of their concern above even the economy and jobs. Tim Rourke of our Governor's Commission on Alcohol and Drug Abuse has stated, "No group is immune to it." It is happening in our cities, our rural areas, and our affluent communities.

And I have been traveling for the year through the 2nd Congressional District bringing together community groups, treatment providers, hospital, physicians, mental health providers, veterans organizations, and law enforcement to try to address this at the local level. I have also been involved with Congressman Guinta and our bipartisan task force to combat the heroin epidemic, and we now have 70 Members of Congress on both sides of the aisle who are concerned about the heroin use in their districts and about how we can do better.

Some of this, we need to unlock some of the inadvertent, probably well-intended public policies of the time, but there are unintended consequences, and we need to unlock and unravel those along the way. We need to make sure that people have access to treatment, to lifelong recovery, and, of course, we need to support our law enforcement.

In New Hampshire alone, we had last year 420 opioid related deaths, up from 326 the year before. Tragically, more people die from overdoses than in car accidents, and this is an astonishing fact. In New Hampshire, we are nearly 4 times more likely to die from an opioid overdose than a car accident. Think about that, 4 times.

Across the country, nearly 260 million prescriptions were written for opioids, enough, according to the Centers for Disease Control, for every American adult to have their own bottle of pills. And we hear stories every day about people getting surgery, car accidents, OB, having a baby by cesarean, or even dentistry.

Part of the stories are young people, teenagers, who are going to get their wisdom teeth removed, and walking out with 30 Percocet. So we have got to do better. And as always, as we look for a way to address the epidemic, we need to call upon all of our citizens and all our institutions to come together. As many in the room know, while our State has one of the highest rates of addiction in the country, we are sadly second to last in access to treatment. The Granite State spends only \$8 per capita on treatment for substance abuse.

One of the issues that I want to address is try to get upstream on this issue. So this morning we will hear about the severity of the epidemic and how the veterans community has been especially hard hit, but how the VA and the veterans community of treatment can be on the cutting edge and bring solutions to our civilian health care, as well as obviously to help veterans who have been historically prescribed opioid at a much, much higher rate, and often, as the chair pointed out, to manage chronic pain.

There is growing awareness that the long-term prescription of opioids to manage chronic pain can have severe and sometimes tragic consequences. It has been reported that veterans are twice as likely to die from accidental overdose compared to non-veterans.

The good news is that the VA has shown success in reducing the amount of opioids prescribed to veterans, but I share the chair's concern that without access to effective alternative treatments and therapies to manage chronic pain, access to mental health services, and access to substance abuse treatment for veterans who become dependent upon prescription opioids, that veterans may illegally obtain and abuse opioid prescriptions, heroin, and fentanyl because they are not receiving the care that they need.

As part of that care, we need to understand and spread the use of alternative treatments and better pain management techniques. We hear reports that veterans with chronic pain are sometimes unable to receive alternative treatments, such as acupuncture therapy, or are unable to get recurring appointments at VA pain clinics. We also hear reports of veterans who struggle with substance use or addiction issues, and they sometimes have to wait months to receive treatment. This is simply unacceptable.

I was proud to join Congressman Guinta in helping to introduce, and I believe Congressman Coffman as well, the Jason Simcakoski Promise Act, which would help improve opioid prescription practices at the VA. And our Full VA Committee passed this out of Committee unanimously last week, and it sent the bill the House floor with our approval. But much more still needs to be done.

One of the issues that I would like to focus on this morning, is how the VA can better share practices in pain management techniques across the country. This is an ongoing concern with the VA. We know that innovative treatments are being developed, but they are in one area, and I am proud to say one, we need to share them throughout the rest of the system.

We will hear today about successful programs to manage and treat chronic pain in Manchester and White River Junction. We will also hear from great programs at Easter Seals of New Hampshire and Harbor Homes, two organizations providing treatment to their veterans struggling with substance use issues and opioid dependence.

And finally, we must explore how we can quickly and effectively implement the best pain management opioid prescription monitoring practices used at Manchester and White River Junction VA at facilities all across the country to prevent veterans from becoming addicted to opioids. I want to know how the VA community providers and State and local governments can come together to get veterans struggling with opioid addiction the most effective treatments they need, and then share these best practices with communities all across the country.

We will not solve the opioid use epidemic in New Hampshire or in the country or help our veterans without dedicated and coordinated efforts. And for that, I thank you, Mr. Coffman, our Chairman, for coming to New Hampshire, and I yield back.

Mr. COFFMAN. Thank you, Representative Kuster, Ranking Member. We will now recognize Representative Guinta for 5 minutes for his opening remarks.

OPENING STATEMENT OF HONORABLE FRANK GUINTA

Mr. GUINTA. Thank you, Mr. Chairman. Thank you for the opportunity to participate in this event here in New Hampshire. I appre-

ciate the opportunity for the Subcommittee to address VA opioid prescription and pain management practices. This is something that has clearly become a critical issue not just within the VA community, but in the community at large.

I want to thank the Subcommittee for its diligent work on the issue. I want to thank my colleagues, the Chairman of the Subcommittee, Mr. Coffman, and the Ranking Member, my colleague from New Hampshire, Ms. Kuster, for her work and for our work in the bipartisan Congressional Task Force to combat heroin and opioid use.

She mentioned that we have upwards of 70 Members now on the task force. That is, I think, indicative of the importance that Congress is placing on this issue. When we began this effort a year ago, we had to explain in many circumstances the importance of why Congress needs to be engaged. Today, fortunately, so many Members appreciate the concern, not just here in New Hampshire, but all across the country. This is an epidemic that we have to fight. This is an epidemic that we will win.

But having opportunities like this to bring the Committee to New Hampshire, to see firsthand what we are doing, utilize best practices, and improve also what we are doing, I think, is critical. So I thank you both for your time and your tireless effort.

I have spent quite a bit of time talking with New Hampshire veterans, New Hampshire civilian individuals who are impacted by opioid use, either over prescription management. And I find that we are at a point where we need to not only review our practices, but we need to pay close attention to the practices we currently utilize, because unfortunately in some circumstances, we may be falling short.

I know here in New England we strive to achieve the best and highest quality of medical care for our veterans. Our veterans here in New Hampshire who have a great opportunity and great energy in working with us on this issue continue to want to press our VA system in the region to be the best it can be. And this hearing, I hope will entertain opportunities for us to make those options better.

I know that over the years in different parts of the country there has been a lot of critique and criticism of the VA system. We are here to try to make sure that we protect the good parts of it and improve those areas that need to be improved, because ultimately the quality and care of our veterans is what is most important to me and to this Committee.

But seeking alternative treatment to opioid use is something that we must shed a greater light upon. For years, opioid use has been the primary practice, not just within the VA system, but outside of the VA system, for pain management. And we have now seen the challenges that it has created. I think a multipronged approach, whether it is within the VA system or outside of the VA system to ensure that we provide proper medical access through drug treatment programs, through recovery or drug courts, is incredibly important, and one of the only ways we are going to try to help manage addiction.

But also on the public safety and criminal side, focusing all of our efforts on making sure that those who are breaking the law,

particularly in the areas of distribution, pay the full price. That debate will continue here in New Hampshire and around the country.

I will be visiting the border next month to get a better sense of how illicit and illegal drugs are coming through the border. After briefings with the DEA, I am shocked and disturbed about the mechanisms that people like El Chapo and others have used to bring drugs into our country. This is something that we are committed to stopping in Congress, and I, again, very much appreciate the Chairman, Mr. Coffman, and the Ranking Member, Ms. Kuster, for their attention not just on the Committee, but within the task force as well.

And I yield back.

Mr. COFFMAN. Thank you, Mr. Kuster. Mr. Guinta.

I would like now to introduce our panel. On the panel we have Mr. Peter Kelleher, Chief Executive Officer of Harbor Homes; Ms. Christine Weber, Director of Substance Abuse Services at the Easter Seals Farnum Center; the Honorable Attorney General, Joseph Foster, New Hampshire Department of Justice; and Dr. Julie Franklin, pain medicine practitioner at the White River Junction, Vermont VA Medical Center, who is accompanied by Dr. Grigory Chernyak, chief of anesthesiology at the Manchester, New Hampshire VA Medical Center.

I ask the witnesses to pleased stand and raise your right hands.
[Witnesses sworn.]

Mr. COFFMAN. Thank you. Please be seated. And let the record reflect that all of the witnesses have answered in the affirmative.

Mr. Kelleher, you are now recognized for 5 minutes.

STATEMENT OF PETER KELLEHER

Mr. KELLEHER. Thank you, Mr. Chairman, and thank you, Congresswoman Kuster, and other distinguished Committee Members.

Mr. COFFMAN. Could you please move the microphone a little bit closer to you? Thank you. If somebody could assist that. Thank you.

Mr. KELLEHER. Thank you. Thank you, Mr. Chairman, and Congresswoman Kuster, and other distinguished Committee Members and guests for this opportunity to address this important issue that is plaguing our veterans and their families. In my role on the Federal Secretary of the VA's Advisory Committee on Homeless Veterans, we have discussed a wide range of topics on homeless veterans, and I look forward to delving further into this conversation.

I am here representing Harbor Homes, Keystone Hall, and other Partnership for Successful Living agencies, a collaboration of six nonprofits in the greater national area that integrate care on the topics of homelessness, behavioral health care, and primary health care. We offer over 80 programs and operate a federally-qualified health center for low income and homeless individuals where we often serve veterans who may not qualify for VA health care.

We operate eight veteran specific programs: supportive services for veterans and their families, a highly successful homeless veteran reintegration program which provides employment service, four grant and per diem programs, and a project based VASH program, and also a robust SAMHSA program, which provides behavioral health services to veterans as well.

As a partnership, we offer a myriad of mental health, substance use, and dual diagnosis programs, especially out of our Harbor Care Health and Wellness Center, a federally qualified health center, and Keystone Hall, one of the largest substance use providers and treatment centers in the State. In our clinic, we offer medication assisted treatment and are endeavoring to provide a full range of medication assisted treatment services, including methadone, under one roof.

Data is varying, but our agency staff reports that approximately 45 to 65 percent of active veterans we are serving are suffering from a substance use disorder, and that 15 to 25 percent of them are specifically struggling with opioid abuse.

The population of veterans who are willing to reflect addiction as a disability on intake into the congressionally mandated Homeless Management Information System frequently cite both alcohol and drug use. For example, in 2014 and 2015, 99 percent of the veterans citing substance abuse reported a disability with both alcohol and drugs. The majority of veterans we work with prefer to admit to alcohol abuse, despite their addiction to other substances.

Our population frequently represents individuals who have not been affiliated with the VA health care system, and, therefore, have not been prescribed opioids for pain management, and instead self-medicate with whatever is readily available.

We have and continue to work in tandem with the VA and other statewide veteran-serving organizations to combat the substance use crisis. It is indisputable by all veteran-serving stakeholders that access to more treatment and more lengthy aftercare is critical to solving this opioid crisis.

Please allow me to offer three suggestions. First, broaden access to the VA health care system to serve more veterans; second, approval for VA medical centers to provide a full range of medication assisted treatment services, such as those provided at the VA Causeway Center in Boston; three, transitional probationary period of 28 days in the grant and per diem programs with co-located outpatient services with veterans with substance use disorder who would not be successful in the present-day iteration of GPD programs.

This means that any veteran that goes into a grant per diem program has a requirement that is part of the congressionally mandated definition of the grant per diem program has to agree to go into a sober living environment, which serves maybe persons with alcohol abuse a little bit more, and is less useful and problematic with people who have opioid addiction.

Allow me to share a recent story of a veteran challenged by his substance abuse who found a path to recovery and independence as a result of the veteran services provided by Harbor Homes and fellow organizations. Our SSVF and HVRP staff, again, worked with the 46-year-old veteran who was not eligible for VA services.

He had been laid off from his job, and then evicted from his home rendering him homeless. During the needs section of his intake assessment, he disclosed that he was in treatment for opioid addiction, and was currently taking Suboxone. The SSVF and HVRP staff were able to move him into permanent housing with some financial assistance and secure him a full-time job.

He received a full benefit package from his employer, which came with a very high deductible. Because of the major increase in his co-pay for Suboxone treatment through private insurance, he could no longer afford it and slipped back into heroin again. The veteran was facing eviction from his housing, and his job was at risk due to his job performance. They then tried to seek through SAMHSA, but because he had been housed through SSVF, he couldn't fit into their criteria.

The SSVF representative knew that Easter Seals had launched a new program with Farnum Center and had five beds for veterans, and within 2 hours he was admitted. He successfully completed the 28-day program, and today is maintaining his Suboxone treatment with financial assistance through Easter Seals Veteran Account Program, and is maintaining his stable housing and employment.

This story is a clear illustration of how we can move the dial with our veterans in crisis when we can rely on each other and reach a common goal. I know we all agree on the premise that substance misuse among veterans can be the result of many inter-related moving parts, struggling with opioid drug usage from readjustment challenges back into civilian life, which often stem from post-traumatic stress disorder, physical injuries, and associated pain management.

Although more attention is being given to the issue of drug addiction among our veteran population, the percentage of veterans who seek help is still disturbingly low. In our experience, veterans are more apt to avoid mentioning at the point of intake that they have a substance abuse addiction or that they are currently using for fear of stigma, creating barriers to getting help, and housing, especially when they're experiencing homelessness.

From my perspective, to evaluate real change in the lives of veterans we serve, we need to look at housing as a critical form of health care. By first tending to the veteran's housing, we can create one tenable link in the braid that is our involvement with their ultimate success.

Along with other supportive services, we can increase our connection with them and can encourage their improved mental and physical health, reduce their dependency on substances, and increase their earning potential through education and employment support. All of this will produce a much higher percentage of those who will be able to maintain their independence, connect with government and nonprofit services, and achieve more successful living.

Thank you.

[THE PREPARED STATEMENT OF PETER KELLEHER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Kelleher, for your testimony today.

Ms. Weber, you are now recognized for 5 minutes.

STATEMENT OF CHRISTINE WEBER

Ms. WEBER. Good morning, and thank you. I'll speak as a provider of substance abuse disorder treatment, in Manchester, New Hampshire, as Ms. Kuster said, the number one public health concern for New Hampshire citizens, veterans and civilians.

The program that I direct in Manchester serves over 2,000 people a year, and I say “people” instead of addicts, or alcoholics, or other terms that can be used to really separate us here in this room—

[Disturbance in the hearing room.]

Ms. WEBER. Should I speak up? Is that okay?

Ms. KUSTER. There you go. You are back on.

Ms. WEBER. I am afraid of the microphone now. We are good? Okay.

So as I was saying, I just wanted to use the term “people” because that is who I work with. That is who are referred to me, military service Member or other—

Mr. COFFMAN. Just one second. Can those in the audience in the back hear? Okay, good. Thank you.

Ms. WEBER. Great. Thanks.

Mr. COFFMAN. Please proceed.

Ms. WEBER. So my staff is tasked to specifically screen our prospective clients by asking the question, “have you ever served in the military,” because there are differences with the citizens that we serve, to inform their care. It is critical that treatment providers, first responders, emergency departments, and treatment liaisons understand how to move forward when a man or a woman answers “yes” to that question. It is not just asking the question. It is informing care afterwards.

So servicemembers present to treatment with us having struggled to navigate when and how to ask for help. If you have heard of the difficulties servicemembers face in accessing adequate medical surgical care, imagine that struggle and add on top of it limited bed availability or substantial substance abuse treatment within the VA system.

For those that are able to identify that they are in need of help, the highest hurdle next to accessing care is the stigma associated with it. Our clients have been in country, in the Yugoslav region, Kuwait, South America, Desert Storm, Desert Shield, OIF, OEF, New Dawn, various regions of Afghanistan, multiple stations throughout the world. None of them imagined the values, conflicts, and the isolative nature of returning to the United States and contemplating suicide because of their need to access substance use disorder treatment.

Prescribers must take the responsibility of opiate prescribing very seriously. Implementing and enforcing substance use disorders curricula for students and licensed practitioners through continuing medical education is an important step in ensuring that physicians are exposed to the nature of the biology of chemical dependence. It’s my hope that the VA and other important health care institutions provide their personnel with ongoing and comprehensive training by American Society of Addiction Medicine Board, certified peers and licensed clinicians, not just their own physicians.

Physicians in this State have met with New Hampshire State Rep Rosenwald to discuss recent bills to include H.B. 1423, relative to prescribing practices, as well as the PDMP, the Prescription Drug Monitoring Program, in New Hampshire. It’s concerning to me as a substance disorder treatment provider that these efforts

might result in legislation that's embraced in language only without enforcement or oversight by the Board of Medicine.

Prevention efforts, utilization of the esprit and referral process, physician training and coordination access to substance treatment, facilities like Vets Choice, are concrete actionable steps. I'm happy to say within the last couple of days Vets Choice has finally approved Farnum Center and its affiliates to be a Vets Choice provider through Medicare. That was a substantial hurdle in the credentialing process.

Regardless of the MOS discharge status for military service, we're seeing an increased population in need of structured clinical intervention support. Without providers and prescribers taking initiative, the mortality rate for this chronic and progressive illness will continue to rise.

Thank you for the opportunity to speak here today. I appreciate it.

[THE PREPARED STATEMENT OF CHRISTINE WEBER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you very much for your testimony, Ms. Weber.

Mr. Foster, attorney general for the State of New Hampshire, you are now recognized for 5 minutes.

STATEMENT OF JOSEPH FOSTER

Mr. FOSTER. Thank you, Mr. Chairman, and I do have some slides. There we are. Great.

Like many States, the illegal and prescription drug opioid crisis is the most pressing public health and public safety challenge facing New Hampshire. It penetrates every aspect of our society, all socioeconomic groups, all races, each gender, all age groups. And it adversely impacts our neighborhoods, our schools, our health care system, our courts, our prisons, our first responders, our businesses, and our highways.

While prescription opioids and heroin remain extremely problematic, unlawfully manufactured fentanyl is at the center of New Hampshire's epidemic. I am going to show some slides that illustrate the depth of the opioid problem here in New Hampshire. They were prepared by the State medical examiner, who is part of our office, and the Department of Safety that houses our State police.

First slide, please.

As you can see, and as Congresswoman Kuster mentioned earlier, in 2000 we had about 50 overdose deaths, and in 2015, 420 confirmed with 14 still awaiting toxicology. And I have been informed as of late February, we already had 60 overdose deaths here in New Hampshire, so the rate is not decreasing.

Next slide, please.

15 years ago, there were about twice as many highway deaths as overdose deaths. Today there are 4 times as many overdose deaths as highway deaths in New Hampshire.

Next slide.

The overdose deaths are prevalent in every region of the State. This shows places where individuals have fatal overdoses. As you can see, it is in the most northern part of the State as well as the

southern part of the State. It doesn't matter what part of the State you are, folks are suffering overdose deaths.

Next slide, please.

And this shows nonfatal overdoses. Thousands of them have occurred statewide. The New Hampshire Bureau of EMS reported that in 2015, 4,235 doses of Narcan were administered around the State. Sometimes more than one dose is necessary when you are dealing with a fentanyl overdose. 1, 2, 3, or 4 can be required to bring the person back.

Next slide, please.

Now, fentanyl and other agents do not discriminate by age. Every age group has experienced sharp increases in overdoses, but for the very young, and the very young as you can see from that slide.

Next slide, please.

Deaths from heroin and fentanyl are fairly new. As you can see, a decade ago deaths from heroin were quite rare, and fentanyl deaths did not exist at all. That changed and has done so with a vengeance.

Next slide, please.

This slide here shows the percentages of deaths that were caused by fentanyl in New Hampshire. 65 were caused exclusively or partially by fentanyl, and we're talking about illegally manufactured fentanyl that comes up mostly from Mexico, and makes it way often to Lawrence, Massachusetts or New York City, and then into our State.

And you can take the slides down.

So what actions is the State doing to address the epidemic? Very broadly speaking, there's really two areas to address the problem. On the supply side, that's mostly a law enforcement function, and on the demand side, broadly speaking, a public health and education function. We cannot arrest our way out of the problem. We need to reduce demand, and with that supply will drop. That said, addressing supply and demand both are critical.

There are a number of law enforcement initiatives taking place within the State and across State lines. This morning I was, in fact, talking to Attorney General Healey from Massachusetts to try to coordinate around the problem in Lawrence. But the problem simply doesn't stop at the State borders. Interrupting supply requires cooperation by and between our Federal, State, county, and local law enforcement agencies, and that is ongoing.

One initiative recently underway is treating overdose deaths as crime scenes. You would think that has happened, but it generally has not happened in the past. They're now being investigated as a crime scene because a crime has been committed there. The goal is to hold those who sold drugs to the victim accountable, and also gather information so it can get the ultimate source of the drugs and try to disrupt the supply into the State.

A lot has happened on the public health side, and in many ways I would say that's more important. In November, our governor called for a special session of our legislature. The House and Senate convened and passed a bill to form a 25-member opioid task force made up of representative and senators. The task force worked aggressively over several weeks and came up with a num-

ber of legislative proposals. Many of those proposals were recommended by the governor's office working closely with a group of her department heads, who she gets together every Wednesday morning. A number of departments are impacted. HHS, Education, Corrections, my office, and other departments, we meet and we make sure this issue is being moved along. So this has been truly a bipartisan effort as it should be.

Some of the legislation already passed includes requiring physicians to query the State's prescription drug monitoring program in most instances. Before, they only had to register but not use it. And it also requires prescription data to be submitted daily. It mandates safe opioid prescribing education for prescribers, and it places pain specialists on the Board of Medicine to ensure expertise when reviewing treatment providers for professional misconduct.

Legislation that's still in process includes expanding funding for our drug courts, reauthorizing New Hampshire's Health Protection Plan. That's our unique form of Medicaid expansion that was adopted in the State. This is key to expanding the State's inadequate treatment network. The plan includes, among other things, of course a substance abuse benefit. If the plan is reauthorized, the provider network will follow because for the first in the State, providers will have a reliable source of payment.

Finally, there's a bill—it was mentioned by Ms. Weber—mandating the adoption of safe and responsible opioid prescribing rules by the professional boards which oversee prescribers of opioids, and my office has been a key driver in that. And so why is that important? Simply put, we need to stop creating new addicts. Overprescribing is a huge problem in our country with about 5 percent of the world's population. Some way, Americans consume 80 percent of the world's opiates. In New Hampshire, the problem is more severe than in many other parts of the country as we rank near the top in the amount long-acting extended release opioids and high dose pain relievers prescribed.

Overprescribing of prescription opiates had led to our heroin problem. According to the CDC, 4 out of 5 heroin addicts were first addicted to prescription opiates. In other words, the prescription opiates led to the fentanyl and heroin deaths I was showing in the slides earlier.

That's why the CDC has issued draft opioid prescribing guidelines, which is supported in a letter co-authored with Attorney General Pam Bondi of Florida, which was joined by 34 other States attorneys general in just 2 business days. So it gives you a sense of the depth of the problem nationwide.

The rules before the legislature adopt many of those guidelines and will require a thoughtful approach to prescribing opiates, and with that, over time, less patients becoming dependent or addicted on opioids. I'm pleased to report that that bill recently passed its first hurdle in Committee with an 18-0 ought to pass recommendation to the full House.

Thank you for allowing me to provide you with an overview of the problem here in New Hampshire. While many of the actions being undertaken at the State level will benefit the veteran population, more needs to be done I know. As you know, the veteran population has been hit especially hard by the epidemic, and I ap-

plaud the work of your Subcommittee. And thank you for you taking the time to come here to New Hampshire to hear from myself and the rest of the speakers.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF JOSEPH FOSTER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Mr. Foster, thank you so much for your testimony. Dr. Franklin, you are now recognized for 5 minutes.

STATEMENT OF JULIE FRANKLIN, M.D.

Dr. FRANKLIN. Good morning, Chairman Coffman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss VA's pain management programs and the use of medications, such as opioids, to treat veterans experiencing acute and chronic pain. I am accompanied today by Dr. Grigory Chernyak, chief of anesthesiology and pain service at the Manchester VA Medical Center.

Chronic pain affects a large portion of the veteran population with about 50 percent of veterans in VA's health care system living with some form of chronic pain. The treatment of veterans' pain is often very complex. Many veterans have survived severe battlefield injuries resulting in lifelong, moderate, to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which can impact their physical abilities, emotional health, and central nervous system.

Chronic pain management is challenging for veterans, their families, and clinicians. VA continues to focus on identifying veteran-centric approaches that can be tailored to individual needs using medication and other modalities. Opioids are an effective treatment for some patient, but they're use requires constant vigilance to minimize risks and adverse effects.

VA launched a system-wide opioid safety initiative in October of 2013, and has seen significant improvement regarding the use of opioids. Today, 105,000 fewer patients are on long-term opioid therapy, and the overall dosage of opioids in the VA system is decreasing.

In March 2015, VA launched the new Opioid Therapy Risk Report tool, which provides detailed information on the risk status of veterans taking opioids. This assists VA primary care clinicians with pain management treatment plans. The tool is a core component of VA's reinvigorated focus on patient safety and effectiveness.

VA data, as well as peer reviewed medical literature, suggests that VA is making progress relative to the rest of the Nation. In December 2014, NIDA-sponsored health service researcher, Dr. Mark Edlund, and his colleagues published an article in the journal Pain. This study of VA pharmacy and administrative data looked at VA opioid prescribing practices for the treatment of chronic non-cancer pain.

The study found that approximately 50 percent of veterans in this cohort received an opioid as part of treatment. Half of these veterans only received them short-term for less than 90 days per year. The average daily dose in VA is 20 morphine equivalents, which is considered modest. VA patients with substance use dis-

order did not receive high-volume opioids at increased rates as has been documented in the non-VA population.

The improvements reflected in this study and since signal an important downward trend in VA's use of opioids. VA expects this trend to remain as it continues its efforts to promote safe and effective pain management therapies.

Manchester VA has established acupuncture and interventional pain programs, and is developing a chiropractic program. Eventually, these services will be part of their functional restorative pain center. Both Manchester and White River Junction VAs' have interdisciplinary pain teams. These interdisciplinary teams include pharmacists, mental health specialists, physiatrists, primary care, and pain specialists. The teams discuss challenging cases and, when appropriate, invite patients to participate.

Since 2011, White River Junction Pain Clinic's monthly patient visits have increased from an average of 40 patient visits per month to over 160. Our availability to see patients has increased, and we have added services, including a chronic opioid therapy clinic, acupuncture, and chiropractic care.

Interventional pain procedure volume has increased during the same period from 20 per month to over 60. From its May 2014 opening through December 2015, the Chronic Opioid Therapy Clinic saw a significant decrease in the number of veterans treated with high dose opioids. Many patients have told us they feel much better since they've reduced their medication doses. For example, one patient was able to travel to Florida with his wife after spending many years homebound.

In conclusion, VA continues to research pain treatment, complementary and integrative medicine, and opioid abuse. VA has been at the forefront of pain management techniques, and we will continue to innovate to better serve the needs of veterans.

Mr. Chairman, we appreciate this Committee's support and encouragement in identifying and resolving challenges as we find new ways to care for veterans. We are prepared to respond to any questions you may have.

[THE PREPARED STATEMENT OF DR. JULIE FRANKLIN APPEARS IN THE APPENDIX]

Mr. COFFMAN. Dr. Franklin, thank you so much for your testimony and for all you do for our veterans.

Walgreens launches a Safe Medication Disposal Program in 39 States. Dr. Franklin, are you aware of a safe medication disposal program or drug takeback program available to veterans at the VA?

Dr. FRANKLIN. Yes. We have, I believe, two different methods. The one I could speak most accurately is that patients can pick up an envelope, which we will send their medications to a centralized repository for disposal.

Mr. COFFMAN. The media has reported that only 52 out of 153 VA medical centers offer alternative therapies to veterans. Dr. Franklin or Dr. Chernyak, although both of your facilities do seem to offer alternatives, why do you think these therapies are not offered at all VA facilities? Who would like to start with that?

Dr. CHERNYAK. I would like to say to you, Mr. Chairman and Ranking Member—

Mr. COFFMAN. I do not think your microphone is on. We might have to shift microphones there.

Dr. FRANKLIN. He can use mine.

Dr. CHERNYAK. First of all, I would like to thank you, Chairman Coffman, and Ranking Member Ms. Kuster, and other Members of the Committee to allow me to be here and speak.

I think one of the problems is that not too many specialists are trained in alternative techniques, such as acupuncture. The other problem is that as far as I know, VA cannot even hire acupuncturists. Acupuncturists are being hired as health technicians with pretty low salary. That is why for the most they are not really interested to work at the VA.

And MDs practice acupuncture at the VA, but there are not too many MDs who are trained in acupuncture. And chiropractors, too, can practice acupuncture at the VA. And, again, there are not too many chiropractors who are specialized in acupuncture.

So VA just recently started chiropractors, as far as I know, a few years ago, and the situation has been improving, but it is still not as good as we would like it to be.

Mr. COFFMAN. I think probably the capacity under the Choice Program is probably somewhat limited in terms of utilizing practitioners within the community that are not in the VA. Okay, that is something that I think the Committee could look into.

Mr. Foster, in your testimony you noted a recent piece of State legislation that was passed that requires physicians to query or ask the State's prescription drug monitoring program in many instances, and it requires prescription data to be submitted daily. Do you have any idea or any data on the compliance rate with this requirement?

Mr. FOSTER. The effective date is that into the future.

Mr. COFFMAN. Oh, okay.

Mr. FOSTER. I can tell you, though, that registrations, we were late to adopt prescription drug monitoring program. I think we may have been the 48th or 49th State to do it. It went into effect in October of 2014. It required physicians and other prescribers to register. We have had very compliance around that, so I am hopeful that that is a sense of how people will take it when they have to start utilizing it as well.

I would imagine it is going to be good. I know that there is commitment to educate folks around it, and also to make the system more user friendly. It is going to be upgraded so it is easier to use for physicians.

Mr. COFFMAN. Do you, if VA physicians are complying with that? I know probably Federal versus State it would probably have to be voluntary, but do you know if they are voluntarily complying with that?

Mr. FOSTER. I do not, and I know there has been a question around whether they have to comply.

Mr. COFFMAN. Okay. Dr. Franklin—

Mr. FOSTER. Dr. Franklin—

Mr. COFFMAN [continued].—can you comment on that?

Dr. FRANKLIN. I can address that question.

Mr. COFFMAN. Sure.

Dr. FRANKLIN. The VA does require annual interrogation of State prescription drug monitoring programs.

VOICES. We cannot hear you.

Mr. FOSTER. I said the VA does require use of State prescription drug monitoring databases, and we have begun to measure this in VISN 1 to make sure that we are looking at least annually for every patient. Both physicians and pharmacists can use the database, and we make a note for the patient's chart.

Mr. COFFMAN. Okay. But is that reporting just to VA authorities, or do you also plan to report to the State?

Dr. FRANKLIN. I believe that New Hampshire is reporting at this time. Vermont was reporting to the State of Vermont, and because of a switch of vendor had to stop.

Mr. COFFMAN. Okay. Thank you very much.

Ms. Kuster, you are now recognized for 5 minutes.

Ms. KUSTER. Sure, thank you. Just to follow-up on this, one of the issues where New Hampshire is such a small State, and we have the border with Vermont and Massachusetts and Maine that Mr. Guinta and I are addressing is an interstate prescription drug monitoring. And then also, just to note that our Committee last week did add an amendment offered by our colleague, Jackie Walorski from Indiana, to increase VA compliance with prescription drug monitoring. So I think it is definitely a critical component.

And part of what made it slow in New Hampshire is it was a voluntary program, and I think it is critically important that all physicians and treatment providers participate.

So I wanted to address my questions to Dr. Franklin and Dr. Chernyak, and if you could just describe a little bit more the program first at White River and then in Manchester for engaging the trends. As it was described to me, it is very hands on. It includes drug monitoring. If you could just share with our audience, and I want to welcome all who are here. We have a number of veterans groups and veteran interest groups. We also have civilian providers. And the goal coming out of this would be to educate the civilian treatment community on the success that you have been having, so if you would share. And you will need to speak like right into the mike. Yeah, thank you.

Dr. FRANKLIN. Thank you. Thank you, Congresswoman Kuster. I believe you are referring to our Chronic Opioid Therapy Treatment Clinic, which it really targets high dose, high-risk veterans, so patients receiving greater than 100 morphine equivalent daily dose, or patients with significant risk for abuse or misuse.

We take all referrals, of course, and give them a two-hour educational program. We then obtain their consent for treatment with chronic opioid therapy and a baseline urine drug screen. They then have a 90-minute individual with our nurse practitioner where she reviews their history, further educates them, performs a physical examination, and reviews previous laboratory results. The veteran and our nurse practitioner then discuss a treatment plan.

The veterans are followed every 28 days. They come in, typically again will leave a urine specimen for evaluation, and other treatments are offered. We may wean doses if we feel that they are not

effective as high doses may actually increase pain. Patients often voluntarily reduce their dose when they really understand how risky these medications are, and other treatments are offered such as acupuncture, chiropractic care, et cetera.

Ms. KUSTER. And have you found that you have been able to decrease the dosage or decrease the use of opiate medication?

Dr. FRANKLIN. We have decreased the doses significantly. In our highest dose group, those receiving greater than 400 morphine equivalent daily dose, we have reduced those patients by 50 percent since the clinic started.

Ms. KUSTER. So 50 percent is a dramatic decrease.

Dr. FRANKLIN. It is a dramatic decrease.

Ms. KUSTER. And could you just comment, if you will, and even anecdotally just quality of life for people that had been essentially debilitated by either chronic pain or the combination of chronic pain and opiate medication?

Dr. FRANKLIN. Yes. Well, for example, we have some patients who have become much more functional and are enjoying life more. Typically, they describe their pain as similar. Occasionally, they have reduced pain as a result of decreasing medications that may be causing opioid hyperalgesia. We have had some patients who are now on Suboxone as they really were suffering from substance use disorder more than pain, and their quality of life has also significantly increased.

Ms. KUSTER. Great. Dr. Chernyak, I just have a minute left in my time this round, but we will come back to it. But could you just add anything from Manchester?

Dr. CHERNYAK. Yeah. In Manchester, we recently started developing our pain program because it was pretty much dysfunctional until recently. And I came on board about 6 months ago, and I established a pretty robust acupuncture program, and I started doing some pain interventional treatments. And we recently were able to recruit another provider who is a chiropractor with strong emphasis in acupuncture. So he used to work in Oklahoma City VA Medical Center where I used to work, and I brought him with me actually. So now he joined our group.

And so, we started treating a lot of patients with acupuncture, and he started doing some chiropractic manipulations as well. And we now are going to add one more treatment modality, which is called for by modulation. It is like low power laser treatment, which is a pretty powerful tool for treating pain and other disorders like chronic pain and some other things like non-healing ulcers, for example.

So we are moving forward, and now we are developing a program which would consolidate pretty much all services that are taking care of chronic pain patients under one roof. That would allow better coordination between services because now they are all separated and working under separate service lines, such as psychiatry, rehab, surgery, and anesthesiology. But we are going to try to solidify them, consolidate them, and work under one philosophy, if you will. And that would allow much better care for our patients.

That is our future plans for the nearest future actually. We are actually working on this project right now.

Ms. KUSTER. Great. Thank you so much. I yield back, Mr. Chair.

Mr. COFFMAN. Thank you, Ms. Kuster. Mr. Guinta, you are now recognized for 5 minutes.

Mr. GUINTA. Thank you, again, to the panelists for being here today. I also want to extend our thanks and appreciation to General Rodell for—

Ms. KUSTER. Yes, thank you.

Mr. COFFMAN. Yes.

Mr. GUINTA [continued].—the use of the facility. He was here in the beginning of the hearing, and I am sure has to attend to other duties, but wanted to acknowledge him on the record.

First, I want to talk to Mr. Foster. Thank you for being here. I agree with you that the focus here has got to be supply and demand, that you have to deal with both. So there is a public safety aspect that I think needs to be addressed. If we have the time later I want to talk to you about that because I think we need to be on the offense, and we need to be very, very specific about the tools, particularly whether it is State or Federal law that we need to utilize.

I want to talk to you more about the demand because you had talked about a couple of things that the governor's commission and the legislature is working. One, you talked about drug court funding. I totally support that. That is completely necessary in order to deal with this as a tool. But the other thing you talked about is doctors have the use of the PDMP.

Would it surprise you to know that I have spoken with, and I agree that they need to utilize that. I have talked to doctors as recently from New Hampshire as last week who have told me that it is an old system. You are in a hospital, and it takes sometimes 45 minutes to access it, and as a result of that, cannot get current information about a patient that they are treating at that particular moment. So that has been a frustration expressed to me. I have talked to the medical society about it here in New Hampshire. They concur with that opinion.

So I was asked to bring that up here today and see what specifically can be done to expedite the improvement of that system.

Mr. FOSTER. Thank you for the question. As I mentioned, the mandatory use of it was pushed forward, and I should say that House Bill 1423 actually requires even more extensive use of it, and that effective date is January 1st. And the reason for that is an acknowledgment that the system is, I guess I will call it, clunky. It is being integrated into EMRs in certain hospitals to make it easier to get to, but it does have to be upgraded.

One of the things I did not mention is, there is additional funding. Believe it or not, the State until recent legislation was passed had a requirement that no State funds be utilized for the PDMP, a very New Hampshire notion I suppose. It was being funded by grants. They have now changed that, and there is some funding coming in. There is also some grants that came in from the Federal government, and it is being utilized to upgrade the system.

So I have heard that is a problem. It has to be reasonably easy to use. I happen to be married to a physician. I know how crazy their day is. It is a dynamic profession with more and more demands on it, and it has to be easy to use; otherwise, we are not going to see it.

One of the things I would love to see happen is the State of New Jersey has developed actually a mobile app for their State PDMP. It would be wonderful if that could be utilized nationwide.

Mr. GUINTA. Which is very similar, I mean, I have an app that I use for my health care that I can monitor and manage exactly from my phone when I need an appointment, what different levels I have. I mean, we should be able to use that kind of technology for this specific kind of circumstance.

Do you have a sense of how timely the resources, the funds would be available to make the upgrade, and then how quickly the upgrade can be made, or is that something you—

Mr. FOSTER. Only to a limited degree. The individual who is responsible, I have talked to her recently. They are talking to the vendor, and my sense is things are on track and that we can meet the dates, you know.

Mr. GUINTA. I think that is critical. The reason this is important and physicians are saying it is important is they want to contribute favorably to knowing when a patient is seen, whether it is an emergent situation or on a regular basis, to verify if they are doctor shopping—

Mr. FOSTER. Absolutely.

Mr. GUINTA [continued].—and how they are getting access. That is why physicians are saying to me it is critical that we focus on this so they have adequate ability to verify information.

I want to go to Ms. Weber very quickly. Mr. Kelleher mentioned 15 to 25 percent of veterans are, and I think he used the term “suffering from substance use disorder.” So that percentage could probably be wider depending on your definition. Given your position at the Farnum Center, can you give us an idea of those 2,000 people, how many are vets, and then subsequently, what are the obstacles that vets are sharing with you in terms of access to care here in our State?

Ms. WEBER. That is a good question. Since June of last year, we have served 30 servicemembers in our inpatient program. That is medical detox and our PHP residential program. Some of the unique challenges on an outpatient basis, working with Reserve members and servicemembers that need to report for drill, is there is concern around what is reported to command.

If a servicemember is working with one of my staff and they are saying that they are struggling either with substance abuse or another risk factor with that, not reporting to drill, is that going to be reported. So there are concerns, and we have partnered with members of the National Guard in making sure that that is not a barrier in accessing care, some of that real legitimate concern. This is their livelihood.

The second piece is really being able to support their family while they are in treatment. I think there is this belief that if you have an active substance use disorder, you do not function in life. But these are people that are working. They are employed. They are supporting families. They are doing the best that they can, and they often have relatively unstable housing situations, like the gentleman at the end of the table spoke of, where they are not able to leave and invest time in themselves to take care of the treatment that they need to support recovery.

Those are a couple of the issues that come to mind.

Mr. GUINTA. Thank you. Yield back.

Mr. COFFMAN. Thank you, Mr. Guinta, for your questions and for being here today for the people of New Hampshire.

Recently a VA nurse pled guilty to stealing opioids while on duty. What is VA's policy for tracking opioids within the VA health care system?

Dr. CHERNYAK. I can talk only for anesthesia pain division, so I cannot talk for any other departments. But we have a machine called Omnicell. In order to check out opioids we need to sign in, check out necessary dose for a particular patient, and then if you have not used the entire dose, you have to waste it with a witness. And both witness and the person who is wasting medication has to enter this information into this Omnicell machine and specify how much was used.

Mr. COFFMAN. I am going to have to ask everybody to speak up in the microphone. The acoustics in this room are just a little bit challenging, and—

Dr. CHERNYAK. I was talking about using Omnicell machine where we need to sign in, check out medications and then for every particular patient. And then if something left over, we need to waste it with a witness. And both witness and the provider who used the medication should indicate the dose, which was actually delivered and the dose which was wasted. So that is how we keep track.

And pharmacy always checks, and if there is any discrepancy, they immediately send us notifications. That is the way we do it in our department, anesthesia and pain anyway.

Mr. COFFMAN. Dr. Franklin?

Dr. FRANKLIN. There are both legal and joint commission standards related to the tracking and disposal of controlled substances. The VA complies with those. Typically when a—

Mr. COFFMAN. Speak up just a little bit more, please.

Dr. FRANKLIN. Typically when a provider, such a nurse or physician who has access to these medications becomes addicted, it is about 30 days before they are either discovered or unfortunately found deceased at work.

Mr. COFFMAN. Okay.

Dr. FRANKLIN. I think that is how these instances typically come to light.

Mr. COFFMAN. Okay. Dr. Franklin, your testimony references 10 different programs, working groups, committees, et cetera, that were developed to deal with pain management. But what successes have these group had? Does VA have proof they are working?

Dr. FRANKLIN. Well, the VA certainly has proof that the use of opioids has decreased. Measuring such things that are important to veterans as quality and level of function is much more difficult and hard to do on an aggregate level. Certainly people have stories of veterans who are doing well.

Mr. COFFMAN. Okay. Are there hours or how many hours of patient care are lost due to these groups? Is that quantifiable?

Dr. FRANKLIN. It is very hard to quantify. Most of the groups actually meet over lunch hours and that kind of thing, so they do not interfere significantly with patient care.

Mr. COFFMAN. Mr. Foster, your office launched an investigation into the marketing of pharmaceutical drugs. Can you comment on the findings of this investigation?

Mr. FOSTER. I wish I could. The pharmaceuticals are fighting us in discovery at this point in time, and so we have not been able to get full-blown discovery from them as of yet. I know a lot of my fellow AGs are launching similar investigations.

I heard yesterday that General Schneiderman from the State of New York reached an agreement with NDO. You may have heard that in the news last night where they are going to terminate improper marketing. Obviously the concern here is that use of opioids, I think, between 1999 and 2010 quadrupled in our country. There are a fair amount of literature and other suggestions that part of that was the marketing of some of these opioids.

The notion was that if your patient had real pain, they would not become addicted particularly to the long-acting opioids because they were more uniform in the way they delivered the medication, and that just does not seem to be true at all. It seems completely false.

Back some years ago, one or more of the opioid companies said they would stop mis-marketing. We are trying to determine whether that is, in fact, the case. We have some doubt about that.

Mr. COFFMAN. Okay. Thank you very much, Mr. Foster. Ms. Kuster, you are now recognized for 5 minutes.

Ms. KUSTER. Thank you. Thank you, Mr. Chair. Again, directing to Dr. Franklin and Dr. Chernyak, one of the concerns that I have is reports across the country that some veterans with chronic pain who have their opioid prescriptions reduced have not been given sufficient support services. So they might have had the prescriptions reduced, canceled without notice, or not giving them the full range of treatment options, and, thus, leading them if they are dependent upon opioids to obtain prescription opioids illegally or use heroin.

How is the VA ensuring that these veterans receive the appropriate treatments for chronic pain or opioid dependence? And how do you balance for veterans with cancer pain or type of pain that they need treatment going forward? How are you striking this balance to make sure that they are not becoming dependent?

Dr. FRANKLIN. To start answering the first part of your question—

Ms. KUSTER. And can you speak up?

Dr. FRANKLIN. Yes.

Ms. KUSTER. It is very difficult to hear.

Dr. FRANKLIN. Sorry. I apologize. I believe that this has to be a case-by-case answer. Every patient needs different treatment. They are a different point in their disease. They have different options available to them.

I can speak to our VA, and we offer treatment to every patient, additional pain treatments. Often, it is not something they are interested in at the time when we are seeing them. We are able to offer substance use disorder treatment really immediately in most cases.

The chief of the Substance Use Disorder Treatment Program at White River Junction will come and meet with us and meet with

the patient when we are talking about our concern for substance use disorder driving their use of opioids.

It is hard to, you know, make a rule that will affect this across the country. But I think hiring good people and making sure that they have the time to do the work that they need to do is a right step. And if you would remind me of the second part of your question.

Ms. KUSTER. Well, I think you have addressed it.

Dr. FRANKLIN. Okay.

Ms. KUSTER. We will hear from Dr. Chernyak. And then one of the things that has been very helpful, and I think Mr. Kelleher brought it up as well, is the concept of ongoing professional education and medical education on pain management and opioid prescribing practices.

So, Dr. Chernyak, if you have anything to add.

Dr. CHERNYAK. Dr. Franklin mentioned that it has to be addressed case by case, and I completely agree. I am just going to give you one example. Probably this week, we had a patient who was expressing some dissatisfaction. He is an opioid patient. He had pretty significant injuries to his lumbar spine and thoracic spine.

Mr. COFFMAN. Please speak up a little bit.

Dr. CHERNYAK [continued]. In a significant amount of pain. And he has been on high doses of opioids, and attempts to reduce the doses or change the opioid regimen was not actually welcomed by him because he was very concerned. And he did not feel like he was cured well enough.

So what we did, we invited him for our interdisciplinary conference and discussed his case with him. It was like three different physicians, providers. We discussed everything with him very carefully, and when he left he was in a completely different mood. So he felt he was really cared about, that he had three different physicians sharing their opinions not only between each other, but with him as well. And that actually changed his attitude completely.

So eventually he agreed with our plan of action. He agreed to switch from opioid to another to reduce the dose, morphine equivalent dose. He agreed to add some other complementary options, such as acupuncture and other things. So that is just one example how we handle this patient. So we invited him for our discussions.

Ms. KUSTER. Great, thank you. My time is almost up, but, Mr. Kelleher, and maybe this is something we could discuss offline for legislation that we hope to introduce. But you mentioned about the grant per diem programs, and I am wondering how the VA could do a better job designing the program to best treat veterans struggling with opioid use disorder.

Mr. KELLEHER. The Grant and Per Diem Program was authorized by Congress quite a while ago. I think it is more than 20 years ago.

Ms. KUSTER. Can you speak right into the mike?

Mr. KELLEHER. It predates all of the opioid crisis that we are facing now. And, you know, it has a requirement that whenever a veteran enters, they must agree to going into a sober living environment. And it works better for persons who are struggling with alcohol abuse, but as we see people coming in with opioid addiction,

their ability to truly be able to function immediately in a sober living environment is very hampered.

And so, I think on the front end, we could benefit from more flexibility to accommodate the opioid addicted population, say, having the first 30 days or 45 days be a place that will allow a connection and treatment to occur and detox.

Ms. KUSTER. Great. Thank you very much.

Mr. KELLEHER. Thank you.

Ms. KUSTER. Thank you. And thank you all for your testimony. I am all set. And thank you, Mr. Chair.

Mr. COFFMAN. Mr. Guinta, you are now recognized for 5 minutes.

Mr. GUINTA. Thank you, Mr. Chairman. I want to follow-up on what Ms. Custer was just talking about. So the VASH Program you have, there are some restrictions in terms of the resources that come from the Federal government to New Hampshire. And I have talked to LaBrie House, for example, in Manchester about that express concern.

I think in your original testimony, I do not know if you used the term of "housing first." I thought that is what I heard. The housing first model gives more flexibility and would allow somebody who is using a substance to gain housing first then treatment. Is that the kind of flexibility that you are suggesting?

Mr. KELLEHER. Yes. Our organization has tried hard to implement a housing first approach, which basically provides a roof over somebody's head first, and does not place requirements on treatment, sobriety, and many other things that are barriers, especially for veterans trying to access permanent housing.

Mr. GUINTA. And if you can try to speak directly into the mike if you can. So I support a housing first model. I did not at first, and I had experience with this when I was mayor of Manchester. And we saw adopting a housing first model greatly impacted the opportunity to help somebody who was an abuser or in a substance use circumstance, whether it was a drug or alcohol, particularly also because there was a dual diagnosis component there with a mental health component. So that is something if we could work on trying to provide flexibility with HUD, that is something that you would utilize.

Mr. KELLEHER. Yes. We are fully supportive of it, you know. Over decades, veterans trying to access housing with barriers, really housing first just allows for, just really getting somebody in a safe, secure place that they can call home, and then worry about how to access all of the treatment and whatever else they might need in their life at a later point in time.

Mr. GUINTA. All right. Thank you, Mr. Kelleher. Dr. Franklin, can you talk to me a little bit about both in New Hampshire and Vermont, if you feel that we are providing adequate alternative services to pain management relative to opioid use.

Dr. FRANKLIN. It is difficult to assess what does "adequate" mean. We feel based on our limited experience so far, that there is a very high demand for alternative services, particularly acupuncture. We are as a VISN, so the New England region, increasing availability of acupuncture services. Whether we will meet the demand is something that we will have to see. And yesterday, we

had a meeting with the network director and talked about how to measure that and how to respond if we find access issues.

Mr. GUINTA. Do you get a sense of whether is an appreciation now within the physicians at the VA that alternatives should be a priority, or is there still an expectation that ongoing opiate prescription is going to continue, prescribing is going to continue?

Dr. FRANKLIN. I think what we are looking for is a balanced treatment. So for some patients, we think that opioids are appropriate long term, and for other patients they are of limited or no value. I do not see much resistance among clinicians at the VA to engaging other therapies.

Mr. GUINTA. The reason I ask that because back in 2015, there was a Center for Complementary and Integrative Health report that noted specifically, "Opioids have not been shown to be superior to non-opioid pain relievers for treating chronic pain." And I think there has been a widely used threshold that there is not an alternative, whether it is in the VA or outside of the VA. So I think that is an important issue to highlight as we try to steer people away from opioid use, the supply and demand issue that our attorney general had talked about.

I want to go to the Choice Card because my colleague, Congresswoman Kuster, and I have co-sponsored the legislation. Mr. Coffman is an advocate of this, of trying to fix the challenges within the Choice Card system. I want to make sure that a veteran, if they cannot access to whether it is chiropractic care, or acupuncture, or any alternative at the VA, how can you assist them utilizing the VA Choice Card to go somewhere else whether they live on the border of New Hampshire and Vermont, or whether they live in the southern part of our State, or up north.

Dr. FRANKLIN. Well, we actually refer to Choice frequently for things like acupuncture. It is an ongoing treatment so the patient would have to come to White River every week for several weeks to get treatment, and we prefer—

Mr. GUINTA. Well, how can we solve that? If, say, you live an hour and a half away. You should not have to drive all the way to White River. The Choice Card, the point behind it is that if you live in Manchester, you should be access care in Manchester. If you live in Portsmouth, you should be able, or Hanover, or Keene. So that is part of the goal of the legislation that we have filed, and this is what I hear from veterans. The point of the card was accessibility and localized accessibility.

If you could work with us on trying to figure out how to resolve that issue, whether it is technical corrections in the law or whether it is administrative at the level of the VA in Washington. I would be happy to work with you on that on behalf of veterans.

Dr. FRANKLIN. I would be happy to work with you.

Mr. GUINTA. Okay. Thank you. I see my time has expired, so I would yield back.

Mr. COFFMAN. Thank you, Mr. Guinta. I want to thank everybody for their testimony today. And one thing I just confirmed with Ranking Member Kuster that when we go back to Washington, we are going to certainly look into this issue about veterans being able to access alternative care within the Choice Program. When you do not offer a particular service that they ought to be accessing in

terms of for pain management, are there any regulatory impediments for that under the existing Choice Program as written. And we will be putting out a joint statement with Mr. Guinta as a participant in this hearing also on that statement.

Our thanks to the witnesses. You are now excused.

Today we have had a chance to hear about alternative treatments for chronic pain management, some provided with VA and some not provided with the VA. Of those programs provided by VA, many are limited to only a few facilities, constricting the value that could be provided to our veterans.

This hearing was necessary to accomplish a number of items, to demonstrate that there are alternative treatments available for chronic pain management, to discuss VA processes for sharing best practices across the country, and to allow VA to inform this Subcommittee what it plans to do to improve coordination of care for all of our veterans.

I would like to once again thank all of our witnesses and audience members for joining in today's conversation, particularly Ranking Member Kuster for bringing me out here today.

Ms. KUSTER. I look forward to my trip to Colorado.

Mr. COFFMAN. She is quite the champion for the State of New Hampshire. And so, there was no option in doing that.

[Laughter.]

Mr. COFFMAN. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and include extraneous material.

Mr. COFFMAN. With that, this hearing is adjourned.

[Whereupon, at 11:54 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Peter Kelleher

March 4, 2016

Addressing VA Opioid Prescriptions and Pain Management Practices-Testimony
Peter Kelleher-President and CEO, Harbor Homes and the Partnership for Successful Living

Thank you to Congresswoman Kuster and other distinguished Committee Members and guests, for this opportunity to address this important issue that is plaguing our veterans and their families. In my role on the Federal VA Advisory Committee on Homeless Veterans, we have discussed a wide range of topics on veteran homelessness and I look forward to delving further into this conversation.

I am here representing Harbor Homes and the Partnership for Successful Living, a collaboration of six non-profits in the Greater Nashua Area that integrate care on the topics of homelessness, behavioral and primary healthcare. We offer over 80 programs and operate a federally qualified health center (FQHC) for low income and homeless individuals where we often serve veterans who may not qualify for VA healthcare. We operate 8 veteran-specific programs: a SSVF program, a highly successful HVRP program, 4 GPD programs, a project-based VASH program, and a robust SAMSHA program.

As a partnership, we offer a myriad of mental health, substance abuse, and dual diagnosis programs, especially out of our Harbor Care Health and Wellness FQHC and Keystone Hall, one of the largest substance use providers and treatment centers in the state. In our clinic, we offer medication-assisted treatment (MAT) and are endeavoring to provide a full range of MAT services including methadone, under one roof.

Data is varying, but our agency staff reports that approximately 45–65% of the active veterans we are serving are suffering from a substance use disorder, and that 15–25% of them are specifically struggling with opioid abuse. The population of veterans who are willing to reflect addiction as a disability upon intake into the congressionally mandated Homeless Management Information System, frequently cite both alcohol and drug use. For example, in 2014 and 2015, 99% of the veterans citing substance abuse reported a disability with both alcohol and drugs. The majority of the veterans we work with prefer to admit to alcohol abuse despite their addiction to other substances. Our population frequently represents individuals who have not been affiliated with the VA healthcare system and therefore have not been prescribed opiates for pain and instead self-medicate with whatever is readily available.

We have and continue to work in tandem with the VA and other statewide veteran serving agencies, to combat the substance abuse crisis. It is indisputable by all veteran serving stakeholders, that access to more treatment options and more lengthy aftercare is critical in solving this opioid crisis.

Please allow me to list three suggestions that should be considered:

- 1)Broaden the VA healthcare services to serve more veterans,
- 2)Approval for VAMCs to provide a full range of medication-assisted treatment services such as those provided at the Causeway Center in Boston,
- 3)Transitional, probationary period of 28 day GPD beds with co-located outpatient services for veterans with SUD who would not be successful in a present day iteration of GPD programs.

Allow me to share a recent story of a veteran, challenged by his substance abuse, who found a path to recovery and independence as a result of the veteran services provided by Harbor Homes and fellow organizations.

Our SSVF and HVRP staff began working with a 46 year old veteran who was not eligible for VA services. He had been laid off from his job and then evicted from his home, rendering him homeless. During the “needs” section of his intake assessment, he disclosed that he was in treatment for opioid addiction and was currently

taking Suboxone. The SSVF and HVRP staff were able to move him into permanent housing with some financial assistance and secured him a full time job. He received a full benefit package from his employer which came with a very high deductible. Because of the major increase in the co-pay cost of his Suboxone treatment through private insurance, he could no longer afford it and slipped back into using heroin again.

The veteran was facing eviction from his housing and his job was at risk due to his job performance. They then tried to seek assistance through SAMSHA but because he had been housed through SSVF, he didn't fit their criteria. The SSVF representative knew that Easter Seals had launched a new program with Farnum and had 5 beds for veterans and within 2 hours he was admitted. He successfully completed the 28 day program and today, is maintaining his Suboxone treatment with financial assistance through Easter Seals Veterans Count program, is maintaining his stable housing and employment.

This story is a clear illustration of how we can move the dial with our veterans in crisis, when we can all rely on each other to reach a common goal.

I know we all agree on the premise that substance misuse among veterans can be a result of many interrelated moving parts; struggling with opioid drug usage from readjustment challenges back into civilian life which often stem from Post-Traumatic Stress Disorder, physical injuries, and associated pain management. Although more attention is being given to the issue of drug addiction among our veteran population, the percentage of veterans who seek help is still disturbingly low. In our experience, veterans are more apt to avoid mentioning at the point of intake, that they may have a substance addiction or that they are currently using, for fear of stigma or creating barriers to getting help and housing, especially when they are experiencing homelessness.

In my perspective, to effectuate real change in the lives of the veterans we serve, we need to look at housing as a critical form of healthcare. By first tending to the veteran's housing, we can create one tenable link in the braid that is our involvement in their ultimate success. Along with other supportive services, we can increase our connection with them and encourage their improved mental and physical health, reduce their dependency on substances, and increase their earning potential through education and employment support. All of this will produce a much higher percentage of those who are able to maintain their independence, connect with government and nonprofit services, and achieve more successful living.

Prepared Statement of Christine Weber

Good morning and thank you for the opportunity to speak on such an important set of issues. Specifically, I will speak as a provider of substance use disorder treatment in New Hampshire, a state where the number one public health crisis, active addiction, will require diligent and informed collaborative efforts if it is to be managed in a meaningful way.

The program that I direct in Manchester serves over 2,000 people a year. I say "people" instead of addicts, alcoholics, or other terms that can be used to create distance between us here today and them. However, amongst the people we serve, there are differences. My staff is tasked to specifically screen prospective clients by asking the question, "Have you ever served in the military," to inform their care. It is critical that treatment providers, first responders, emergency departments and treatment liaisons understand how to move forward when a man or woman in their care answers "Yes" to this question.

Service members present to treatment having struggled to navigate when and how to ask for help. If you have heard the difficulties servicemembers face in accessing adequate medical/surgical care, imagine that struggle, and add limited bed availability or substantial substance abuse treatment within the VA system. For those that are able to identify that they are in need of help, the highest hurdle next to access to care is stigma. Our clients have been in country in the Yugoslav region, Kuwait, South America, Desert Storm, Vietnam, Operation Iraqi Freedom, Enduring Freedom, New Dawn, various regions of Afghanistan and multiple stations throughout the world. None of them imagined the values conflicts and isolative nature of addiction would lead them to contemplating suicide or treatment for alcohol and drug dependence.

Prescribers must take the responsibility of opiate prescribing very seriously. Implementing and enforcing substance use disorder curricula for students and licensed practitioners through Continuing Medical Education is an important step in ensuring that physicians are exposed to the nature of the biology of chemical dependence.

It is my hope that the VA and other important healthcare institutions provide their personnel with ongoing and comprehensive training by American Society of Addiction Medicine Board Certified peers and licensed clinicians.

Physicians have met with NH State Representative Rosenwald to discuss recent bill(s) to include NH HB1423 relative to prescribing practices as well as the PDMP (Prescription Drug Monitoring Program) in New Hampshire. It is concerning as a substance disorder treatment provider that these efforts may result in legislation that is embraced in language only, without enforcement or oversight by the Board of Medicine.

Prevention efforts, utilization of the Screening/Brief/Intervention and Referral process, physician training, and coordinating access to substance use disorder treatment facilities via Vets Choice are all concrete, actionable steps.

Regardless of MOS, discharge status, or military service, we are seeing an increase population in need of structured, clinical intervention and support. Without providers and prescribers taking initiative, the mortality rate for this chronic and progressive illness will continue to rise.

Prepared Statement of Joseph Foster

Like many states, the illegal and prescription drug opioid crisis is the most pressing public health and public safety challenge facing New Hampshire.

It penetrates every aspect of our society; all socio-economic groups; all races; each gender and age groups; and it adversely impacts our neighborhoods, our schools, our healthcare system, our courts, our prisons, our first responders, our businesses and our highways.

While prescription opioids and Heroin remain extremely problematic, unlawfully manufactured Fentanyl is at the center of the State's epidemic.

I am going to show some slides that illustrate the depth of the opioid problem in NH prepared by our state Medical Examiner and our Department of Safety.

Slide 1—Drug Deaths

- In 2000, 50 deaths
- In 2015, 420 confirmed with 14 still awaiting toxicology.

Slide 2—Highway Deaths Compared to Overdose Deaths

Fifteen years ago there were twice as many highway deaths as overdose deaths—today, there are 4 times as many overdose deaths as highway deaths.

Slide 3—Deaths by Geography

Overdose deaths are prevalent in every region of the State.

Slide 3—Narcotic Dosage

Overdoses—thousands of them occurred statewide. The NH Bureau of EMS reported that in 2015, 4,235 doses of Narcotic were administered in the State.

Slide 4—Deaths by Age

Fentanyl and other agents do not discriminate by age. Every age group has experienced sharp increases in overdoses, but for the very young and very old.

Slide 5—Heroin and Fentanyl

Deaths from Heroin and Fentanyl are fairly new. As you can see, a decade ago deaths from Heroin were rare—and Fentanyl deaths did not occur. That changed and did so with a vengeance.

Slide 6—2015 Data —Percentage of Heroin/Fentanyl Deaths and Opiates

Of the 420 confirmed drug deaths, 65% were caused exclusively or partially by Fentanyl.

ACTIONS

So, what are we doing in NH to address this epidemic?

Very broadly speaking, there are two areas to address this problem: on the supply side—mostly a law enforcement function; and on the demand side—broadly speaking, a public health and education function.

We cannot arrest our way out of the problem. We need to reduce demand and with that supply will drop. That said addressing both supply and demand is critical.

There are a number of law enforcement initiatives taking place within the State and across state lines. The problem does not stop at our state borders. Interrupting

supply requires cooperation by and between our federal, state, county and local law enforcement agencies.

One such initiative is treating our overdose deaths as crime scenes. The goal is to hold those who sold the drugs to the victim accountable and to gather information so we can get the ultimate source of the drugs and disrupt the supply.

A lot has happened on the public health side and in many ways is more important.

In November, our Governor called a Special Session of the Legislature. The House and Senate convened and passed a bill forming a 25-member Opioid Task Force made up of Representatives and Senators. The Task Force worked aggressively over several weeks and came up with a number of legislative proposals.

Many proposals were recommended by the Governor's Office working closely with a group of her Department heads, including my office. This has truly been a bi-partisan effort-as it should be.

Some of the legislation already passed:

- Requires physicians to query the State's Prescription Drug-Monitoring Program in many instances; and requires prescription data be submitted daily;
- Mandates safe opiate prescribing education for prescribers; and
- Placed pain specialists on the Board of Medicine to insure expertise when reviewing treatment providers for professional misconduct.

Legislation in process would:

- Expand funding for drug courts.
- Reauthorize the NH Health Protection Plan-our unique form of Medicaid expansion. This is key to expanding the State's inadequate treatment network. The Plan includes a substance abuse benefit. If the Plan is reauthorized, the provider network will follow because, for the first time, providers will have a reliable source of payment.
- Mandates adoption of safe and responsible opiate prescribing rules by the professional boards which oversee prescribers of opioids. My office has been a key driver behind this legislation.

Why is that important? Overprescribing is a huge problem in this country. With about 5% of the world's population, some say Americans consume 80% of the world's opiates.

In NH the problem is more severe than in many other parts of the country as we rank near the top in the amount of long acting/extended release opioid and high dose pain relievers prescribed.

Overprescribing of prescription opioids has led to our heroin problem. According to the CDC, 4 out of 5 heroin addicts were addicted to prescription opiates first. In other words, prescription opiates led to the Fentanyl and Heroin deaths I mentioned earlier.

That is why the CDC has issued draft opiate prescribing guidelines which I supported in a letter co-authored with Attorney General Bondi of Florida which was joined by 34 other state Attorneys General. The rules before the Legislature adopt many of those guidelines and will require a thoughtful approach to prescribing opiates and with that, over time, less patients becoming dependent or addicted to opioids.

Thank you for allowing me to provide you an overview of the problem here in NH. While many of the actions being undertaken at the state level will benefit the veteran population more needs to be done. I know the veteran population has been hit especially hard by the epidemic and I applaud the work of your Committee and thank you for taking the time to come here to NH to hear from myself and the rest of the speakers.

Prepared Statement of Dr. Julie Franklin

Good morning, Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee. Thank you for the opportunity to participate in this hearing and to discuss VA's pain management programs and the use of medications, particularly opioids, to treat Veterans experiencing acute and chronic pain. I am accompanied today by Dr. Grigory Chernyak, Chief of Anesthesia and Pain Service, at the Manchester, New Hampshire VAMC.

Chronic Pain Across the Nation

Chronic pain affects the Veteran population, with almost 60 percent of returning Veterans from the Middle East and more than 50 percent of older Veterans in the VA health care system living with some form of chronic pain. The treatment of Veterans' pain is often very complex. Many of our Veterans have survived severe battlefield injuries, some repeated, resulting in life-long moderate to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which can impact their physical abilities, emotional health, and central nervous system. It is important to note as well that there is limited clinical trial data supporting the use of opioids for chronic pain¹ and so VHA is committed to reducing overreliance on opioid medicines especially in light of the severe negative consequences many patients on opioids risk.

Current VHA Pain Management Collaboration

To implement effective management of pain, VHA's National Pain Program oversees several work groups and a National Pain Management Strategy Coordinating Committee representing the VHA offices of nursing, pharmacy, mental health, primary care, anesthesia, education, integrative health, and physical medicine and rehabilitation. Working with the field, these groups develop, review and communicate strong pain management practices to VHA clinicians and clinical teams.

For example, the VHA Pain Leadership Group, consisting of Pain Points of Contact for the Veterans Integrated Service Networks (VISNs) and facilities, meets monthly with the National Pain Program to discuss policy, programs, and clinical issues and disseminate information to the field as well as to provide feedback to VACO leadership about these programs. Several of these groups are chartered to promote the transformation of pain care in VHA at all levels of the Stepped Care Model: the Pain Patient Aligned Care Team (PACT) Initiative Tactical Advisory Group focuses on primary care issues; the Pain Medicine Specialty Team (PMST) Workgroup coordinates and provides standards for specialty pain services; the Interdisciplinary Pain Management Workgroup focuses on developing Commission on Accreditation of Rehabilitation Facilities (CARF) certified tertiary care pain management programs for complex patients.

The Opioid Safety Initiative (OSI) Toolkit Task Force has published and promoted 16 evidenced-based documents and presentations to support the Academic Detailing model of the OSI. More information on the OSI Toolkit can be found at the following link: (<http://vawww.va.gov/PAINMANAGEMENT/index.asp>).

The Department of Defense (DoD)-VA Health Executive Council's Pain Management Workgroup (PMWG) oversees joint projects with DoD including the two Joint Investment Fund (JIF) projects, the Joint Pain Education and Training Project and the Tiered Acupuncture Training Across Clinical Settings, and other projects that aim to standardize good pain care across DoD and VHA.

Pain Management

In Manchester, VA offers an Interventional Pain Program, Acupuncture Program, Physical and Occupational therapies, and is in the process of creating Chiropractic and other Complementary and Integrative Medicine programs to meet the needs of Veterans. We closely collaborate with VHA pharmacy on opioid prescribing to monitor prescribing to our Veterans. We hold Interdisciplinary Pain Team meetings weekly to collaborate on the treatment we provide to the 488 patients currently in our program. The process lends itself to frank and open discussions which focus on real time issues and improvements to the program. Manchester outcomes include: working as a multimodal team to cultivate change with the culture of prescribing. Interdisciplinary team prescribers include: Surgical, SPRS (Sensory and Physical Rehabilitation Services), Primary Care, Mental Health, Pharmacy, QM, Medical, CLC (Long term care, rehabilitation Palliative care), and Urgent Care. This Interdisciplinary team has allowed Manchester providers to decrease opioid dispensing from FY 2011 to 2014 by 6 percent.

Since 2011, our Pain Clinic has seen its monthly patient clinic visits increase from an average of 40 visits per month to over 160. We have increased our availability to see patients on an ongoing basis and have added services for patients including a Chronic Opioid Therapy Clinic and acupuncture. Our Interventional Pain Proce-

¹Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik JG, Blazina I, Dana T, Bougatsos C, Turner J. The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain. Evidence Report/Technology Assessment No. 218. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2012-00014-I.) AHRQ Publication No. 14-E005-EF. Rockville, MD: Agency for Healthcare Research and Quality; September 2014. Available at <https://www.effectivehealthcare.ahrq.gov/ehc/products/557/1988/chronic-pain-opioid-treatment-executive-141022.pdf> downloaded 2-24-2016.

dures volumes have increased during the same time period from 20 procedures per month to over 60. We offer evidence-based psychotherapy for chronic pain. White River Junction is also the lead site for the VISN 1 Pain Mini Residency program. One of the patients treated with acupuncture started driving again, as well as taking care of her family after years of disability.

Since our Chronic Opioid Therapy Clinic opened in May 2014 through December 31, 2015, we have seen a 50 percent decrease in the number of Veterans treated with the highest doses of opioids (greater than 400 morphine equivalent daily dose). We have seen a 41 percent decrease in the number of patients treated with high dose opioids (greater than 200 morphine equivalent daily dose) during the same time period. Many of our patients have expressed that they are feeling much better since reducing their doses of medications.

Our VISN also takes Pain Management seriously. VISN 1 declared Pain Management as one of its five top priorities in 2015. The VISN committed to improving opioid safety and increasing access to other modes of treating pain. We will have an acupuncture clinic at each facility, four Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited Pain Rehabilitation programs, and increased access to, iRest, and evidence-based psychotherapy for pain as a result of this commitment.

Approximately 4–5 years ago, Dr. Chernyak initiated acupuncture services and established an acupuncture clinic at the Oklahoma City VAMC. This clinic turned out to be very successful in helping Veterans. During this period, many Veterans contacted the administration with testimonial letters and with requests to expand this service to make it more accessible for Veterans. As a result, the Oklahoma City VAMC hired a dedicated Acupuncture specialist, and today this clinic sees approximately 50 patient visits per week.

Acupuncture has been used in the treatment of different kinds of acute and chronic pain, chronic headaches, migraines, various addiction problems, psychological issues such as PTSD, depression, anxiety, and in many other health disorders. This mode of treatment has withstood the test of time, as it has successfully survived several thousand years of clinical practice in various forms and in many different cultures. It is not unusual to see instances when very difficult health conditions, especially those resistant to conventional treatment modalities, are successfully treated with acupuncture.

Currently, new, high tech methods of acupuncture point stimulation are clinically available, such as the use of low level laser therapy (i.e., cold laser therapy). This method allows the clinician to achieve an effect without actually penetrating the skin with a needle and, without causing the pain sometimes associated with needle insertion. Cold laser therapy, or photobiomodulation therapy, is a non-invasive treatment modality that we are working to implement in our Integrative Pain clinic.

Both Dr. Chernyak and my goal is to build a robust Integrative Pain Center with a strong emphasis on Complementary and Integrative Medicine approaches to the treatment of pain at all our facilities. This approach would also address the issue of opioid overuse. Usually, health care providers tend to refer their patients for Complementary and Integrative Medicine therapies for chronic pain issues only after all other treatment modalities have failed. Therefore, Complementary and Integrative Medicine therapies are often considered as a last resort or a therapy of despair. Dr. Chernyak believes that this practice should be reversed and that Complementary and Integrative Medicine therapies should be offered at a much earlier stage in the treatment process along with physical therapy. Complementary and Integrative Medicine modalities, to include acupuncture, should be considered before more invasive treatment options are sought and most certainly before chronic opioid pain management is prescribed. Acupuncture has the added benefit of being inexpensive, and in our experience has virtually no side effects when performed by properly trained personnel.

Both Manchester and White River Junction have added positions to ensure that we have the expertise to provide interventional pain injections or even surgical help. Furthermore, it is our desire that both of our facilities will be able to initiate and conduct a number of research projects and possibly a pain fellowship program in collaboration with one of the teaching institutions.

VA's Progress in Pain Management

Chronic pain management is challenging for Veterans and clinicians - VA continues to focus on identifying Veteran-centric approaches that can be tailored to individual needs using medication and other modalities. Opioids are an effective treatment, but their use requires constant vigilance to minimize risks and adverse effects. VA launched a system-wide OSI in October 2013, and has seen significant improvement in the use of opioids. The Specialty Care Access Network-Extension for

Community Healthcare Outcomes (SCAN–ECHO) and the OSI, have been designed to integrate into the Academic Detailing model. Academic Detailing is a proven method in changing clinicians’ behavior when addressing a difficult medical problem in a population. Academic Detailing combines longitudinal monitoring of clinical practices, regular feedback to providers on performance, and education and training in safer and more effective pain management.

Most recently, in March 2015, we launched the new Opioid Therapy Risk Report tool which provides detailed information on the risk status of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. This tool is a core component of our reinvigorated focus on patient safety and effectiveness.

VA’s own data, as well as the peer-reviewed medical literature, suggest that VA is making progress relative to the rest of the Nation. In December 2014, an independent study by RTI International health services researcher, Mark Edlund, MD, PhD and colleagues, supported by a grant from the National Institute of Drug Abuse, was published in the journal PAIN¹. This study, using VHA pharmacy and administrative data, reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance use disorders and comorbid chronic non-cancer pain.

Dr. Edlund and his colleagues found that:

- About 50 percent of veteran with chronic non-cancer pain in this cohort received an opioid as part of treatment.
- Half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e.: for less than 90 days per year);
- The daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD),
- And the use of high-volume opioids (in terms of total annual dose) is not increased in VA patients with substance use disorders as has been found to be the case in non-VA patients.

Although it is good to have this information, a confirmation of our efforts for several years, starting with the “high alert” opioid initiative in 2008 and multiple educational offerings, by no means is VA’s work finished. By virtue of VA’s central national role in medical student education and residency training of primary care physicians and providers, VA will be playing a major role in this transformation effort. But we have already started with our robust education and training programs for primary care, such as SCAN–ECHO, Mini-residency, Community of Practice calls, two JIF training programs with DoD, and dissemination of the OSI Toolkit.

A key development is a Joint Incentive Fund DoD–VA project to improve Veterans’ and Servicemembers’ access to Complementary and Integrative Medicine, the “Tiered Acupuncture Training Across Clinical Settings” (ATACS) project. ATACS represents VHA’s initiative to make evidence-based Complementary and Integrative Medicine therapies widely available to our Veterans throughout VHA. A VHA and DoD network of medical acupuncturists are being identified and trained in Battlefield (auricular) Acupuncture by regional training conferences organized jointly by VHA and DoD. The goal of the project is for them to return to their facilities and VISNs with the skills to train local providers in Battlefield Acupuncture, which has been used successfully in DoD front-line clinics around the world. This initiative ultimately aims to provide all Veterans with access to this intervention, and a wider array of pain management choices generally, when they present with chronic pain. Many providers in VISN 1 have received this training either through the ATACS program or through the Pain Mini-Residency program.

Complementary and Integrative Medicine

VHA leadership has identified as its number one strategic goal “to provide Veterans personalized, proactive, patient-driven health care.” Integrated Health Care (IH), which includes Complementary and Integrative Medicine approaches, provides a framework that aligns with personalized, proactive, patient-driven care. There is growing evidence for effectiveness of non-pharmacological approaches as part of a comprehensive care plan for chronic pain which includes acupuncture, massage and spinal manipulation. As I have described, these are all being made available to Veterans.

In 2011, VA’s Healthcare Analysis and Information Group published a report on Complementary and Integrative Medicine in VA. At that time, 89 percent of VHA

¹Edlund MJ et al, Patterns of opioid use for chronic noncancer pain in the Veterans Health Administration from 2009 to 2011. PAIN 155(2014) 2337–2343.

facilities offered some form of Complementary and Integrative Medicine however, there was extensive variability regarding the degree, level, and spectrum of services being offered in VHA. The top reasons for offering Complementary and Integrative Medicine included promotion of wellness, patient preferences; and adjunct to chronic disease management. The conditions most commonly treated with Complementary and Integrative Medicine include: stress management, anxiety disorders, PTSD, depression, and back pain.

VA recognizes the importance and benefits of recreational therapy in the rehabilitation of Veterans with disabilities. Currently, over 30 VA medical centers across the country participate in therapeutic riding programs. These programs use equine assisted therapeutic activities to promote healing and rehabilitation of Veterans with a variety of disabilities and medical conditions (e.g. traumatic brain injury, polytrauma). VA facilities participating in such programs utilize their local appropriated funds to contract for these services. Facilities may also be able to use money in the General Post Fund, a trust fund administered by the Department, to pay for these services.

A monthly IH community of practice conference call provides VHA facilities national updates, strong practices, and new developments in the field and research findings related to IH.

The Opioid Safety Initiative (OSI)

The OSI was chartered by the Under Secretary for Health in August 2012. The OSI was piloted in several VISNs. Based on the results of these pilot programs, OSI was implemented nationwide in August 2013. The OSI objective is to make the totality of opioid use visible at all levels in the organization. It includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events), and the average MEDD of opioids. Results of key clinical metrics for VHA measured by the OSI from Quarter 4 Fiscal Year 2012 (beginning in July 2012) to Quarter 4 Fiscal Year 2015 (ending in September 2015) there are:

- 125,307 fewer patients receiving opioids (679,376 patients to 554,069 patients, an 18.44 percent reduction);
- 42,141 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 80,492 patients, a 34.36 percent reduction);
- 94,507 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 255,108, a 58.84 percent increase);
- 105,543 fewer patients on long-term opioid therapy (438,329 to 332,786, a 24.08 percent reduction);
- The overall dosage of opioids is decreasing in the VA system as 15,172 fewer patients (59,499 patients to 44,327 patients, a 25.5percent reduction) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing.

The changes in prescribing and consumption are occurring at a modest pace, and the OSI dashboard metrics indicate the overall trends are moving in the desired direction. OSI will be implemented in a cautious and measured way to give VA time to build the infrastructure and processes necessary to allow VA clinicians to incorporate new pain management strategies into their treatment approaches. A measured process will also give VA patients time to adjust to new treatment options and to mitigate any patient dissatisfaction that may accompany these changes.

While these changes may appear to be modest given the size of the VA patient population, they signal an important trend in VA's use of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs yielding significant results have been identified and are being studied as strong practice leaders. VA intends to implement safe opioid prescribing training for all prescribers in response to the Presidential Memorandum Addressing Prescription Drug Abuse and Heroin Use².

Conclusion

In conclusion, VA continues to research pain treatment, Complementary and Integrative Medicine and opioid abuse. While we know our work to improve pain management programs and the use of medications will never truly be finished, VA has

²The white House Office of the Press Secretary. October 21, 2015. Presidential Memorandum Addressing Prescription Drug Abuse and Heroin Use-Available at <https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin> downloaded 2-24-2016

been at the forefront in dealing with pain management, and we will continue to do so to better serve the needs of Veterans.

Mr. Chairman, we appreciate this Subcommittee's support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. My colleague and I are prepared to respond to any questions you may have.

